4. b. xvii. (i) CASE MANAGEMENT SERVICES: See Supplement 3 to Attachment 3.1A.

(j) SINGLE OR DOUBLE LUNG, AND COMBINED HEART-LUNG TRANSPLANTS. Exclusion of single lung, double lung, and heart/lung transplants will be waived for EPSDT patients. All other requirements regarding the pre-authorization of hospital stays and use of Medicare certified transplant facilities will continue to apply.

4. c. Family Planning Services and Supplies for Persons of Child Bearing Age: The Department will provide family planning services which include: counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

5. a. Physican Services: The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations Sections 16.03.09.065 and 16.03.09.070.02, and listed below.

Excluded Services: Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by the Medicare program are excluded from Medicaid payment. Non-medically necessary cosmetic surgery is excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval by the Department.

Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy are excluded from Medicaid payment.

Procedures, counseling, office exams and testing for the inducement of fertility are excluded from Medicaid payment.

For transplant coverage, see Attachment 3.1-E.

Drugs supplied to patients for self-administration other than those allowed under Idaho Department and Welfare Rules and Regulations Section 03.9126 are excluded from Medicaid payment.

The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department, is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

5. a. Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either seperately or as part of a vision exam). Individuals with a diagnosis of Glaucoma are excluded from this limitation.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

5. b. Medical and Surgical Furnished by a Dentist: The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 915.

Dentist Limitations: Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department. All hospitalizations for dental care must be prior approved by the Department. Non medically necessary cosmetic services are excluded from Medicaid payment. Drugs supplied to patients for self-administration other than those allowed under Rules Governing Medical Assistance, IDAPA 16.03.09.805 through 818 are excluded from Medicaid payment.

6. a. Podiatrist's Services are limited to treatment of acute foot conditions.

b. Optometrists' Services are limited to providing eye examination and eye glasses as described in section 12.d. Eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnoses and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

c. Chiropractic Services are limited for payment to a total of twenty-four (24) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

d. Services Under Other Practitioners includes those services provided a physician assistant as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1A Program Description 5a. Physician Services.

7. Home Health Services

a. (i) Home Health Visits: Home Health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, or licensed nurse.

(ii) Services by a licensed nurse: Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(1).

b. Home Health Aide Services Provided by a Home Health Agency: Home health aide visits are limited to a total of one hundred (100) visits per recipient per calendar year. Included in the total visit count is all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination.

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home:

Program Requirements: To control utilization, all medical equipment and medical supplies must be ordered in writing by a physician. Items not specifically listed in the Rules Governing Medical Assistance, IDAPA 16.03.09.108, 107 and 108, will require prior authorization by the Department. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

d. Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services Provided by a Home Health Agency or Medical Rehabilitation Facility:

Home Health Agency visits by Physical Therapists and Occupational therapists are limited to a total of one-hundred (100) visits per recipient per calendar year, included in the total visit is all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Speech pathology and audiology services are not provided for under home health services.

9. Clinic Services:

Clinic services which are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

a. Mental Health Clinics:

Services provided in a mental health clinic are outlined in the Rules Governing Medical Assistance, IDAPA 16.03.09.465 through 469. Service limitations as follows:

(i) Psychotherapy Services: As set forth in Rules Governing Medical Assistance, IDAPA 16.03.09.469.01 through 03 Are limited to forty-five (45) hours per calendar year.

(ii) Partial Care Services: Partial care treatment will be limited to fifty-six (56) hours per week per eligible client.

(iii) Evaluation and Diagnostic Services: A combination of any evaluative or diagnostic services and care plan development is limited to twelve (12) hours for each eligible recipient per calendar year.

b. Ambulatory Surgical Centers (ASC):

Ambulatory surgical center services are outlined in Rules Governing Medical Assistance, IDAPA 16.03.09.121. Service limitations are as follows:

(i) Must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

c. Diagnostic Screening Clinics:

Services provided in a diagnostic screening clinic are outlined in the Rules Governing Medical Assistance, IDAPA 16.03.09.460. Service limitations are as follows: five (5) hours of medical social services per eligible per state fiscal year is the maximum allowable.

9. d. Diabetes Education and Training Clinics:

Clinics which provide diabetic education and training services are outlined in the Rules Governing Medical Assistance, IDAPA 16.03.09.128. Outpatient diabetes education and training services will be covered under the following conditions:

(i) The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

(ii) The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

(iii) Service Description. Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.

(iv) To receive diabetic counseling, the following conditions apply to each patient.

(a) The patient must have a written order by his or her primary care physician or physician extender referring the patient to the program.

(b) The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes millitus and dosage administration of oral hypoglycemic agents.

9. d. (v) The medical necessity for diabetic education and training are evidenced by the following:

(a) a recent diagnosis of diabetes within ninety (90) days or enrollment with no history of prior diabetic education; or,

(b) uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or

(c) recent manifestation resulting from poor diabetes control including neuropathy, retinopathy recurrent hypoglycemia, repeated infections, or non-healing wounds.

(vi) Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years.

10. Dental Services: Dental services include diagnostic, preventive, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services, and are purchased when provided by a licensed dentist or denturist as described in the Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 916.

Dental Service Limitations: All covered dental services, limitations on specific services, excluded services, billing codes and payment policies are stated in the Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 916. A dental consultant will review requests for prior authorization, with accompanying documentation, to determine approval or denial.

Procedures not recognized by the American Dental Association are not covered.

11. Physical Therapy and Related Services:

a. Physical Therapy Services - Independent Practitioners:

Payment for physical therapy services by a licensed physical therapist as defined under 42 CFR 440.110 by direct order of a physician as a part of a plan of care, and be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office. Recipients are limited to twenty-five (25) visits per calendar year without prior authorization by the Department. Included in this limitation are outpatient hospital, independent providers, and physical therapy under school-based services and developmental disability agencies.

b. Services for Individuals with Hearing Disorders-Audiology Services

The Department will pay for audiometric services and supplies according to Rules Governing Medical Assistance, IDAPA 16.03.09.108. The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician . Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.

12. Prescribed drugs and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist:

b. Dentures:

The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions.

If full dentures are inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed.

Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the client is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed.

Laboratory and professional fees may be paid for a partial or complete denture if the client: decides not to complete the partial or complete denture; leaves the state; cannot be located; expires. An invoice listing lab and professional fees is required when prior authorizing. Specific coverage information is found in Rules Governing Medical Assistance, IDAPA 16.03.09.906 through 908.

c. Prosthetic Devices:

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body. Hearing aids and related services will be covered by the Department.

Limitations: Prosthetic and orthotic devices and services will be purchased only if prescribed by a physician and pre-authorized by the Department. All prosthetic and orthotic devices (excluding hearing aids) that require fitting shall be provided by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase one (1) hearing aid per recipient with prior approval by the Department. Follow up services are included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

CASE MANAGEMENT SERVICES

A) Target Group: Medicaid eligible children age birth to twenty-one (21) years of age who meet the medical necessity criteria.

Medical Necessity Criteria: Medical necessity criteria for Service Coordination (SC) services under EPSDT are as follows: Children eligible for SC must meet one of the following diagnostic criteria: Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. Children who have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illness, or injuries. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one (1) year or more. Children eligible for SC must have one (1) or more of the following problems associated with their diagnosis: The condition requires multiple services providers and treatments; or the condition has resulted in a level of functioning below age norm in one (1) or more life areas, such as school, family, or community; or there is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition; or there is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or further complications may occur as a result of the condition without provision of services coordination services; and the family needs a service coordinator to assist them to access medical and other services for the child.

B) Areas of the State which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C) Comparability of Services.

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D) Description of Service.

SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to implementation. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four (24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems.

E) Qualifications of Providers.

SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: Demonstrated experience and competency in providing all core elements of service coordination services to children meeting the medical necessity criteria. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications.

Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: Must be a licensed M.D., D.O., social worker, R.N., or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria. Individuals without the one (1) year experience may gain this experience by working for one (1) year under the supervision of an individual who meets the above criteria. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. Pass a criminal history background check. The caseload of service coordinators will be limited to fifty (50) when using one (1) or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. A waiver to the caseload limit may be granted by the Department on a case by case basis and must meet the following criteria: The availability of service coordinators is not sufficient to meet the needs of the service area; or the recipient's family who has chosen the particular service coordinator who has reached his limit, has just cause to need that particular provider over other available providers; or the individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) recipients; and the request for waiver must include: The time period for which the waiver is requested; and the alternative caseload limit requested; and documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purpose of the program, or adversely affect the health and safety of any of the service coordinator's consumers. The Department may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of the service coordination services provided.

F) The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1) Eligible recipients will have free choice of the providers of case management services.

2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.